Unannounced Care Inspection

Name of Establishment:	**Bannview House Care Home**
RQIA Number:	**11103**
Date of Inspection:	**20 November 2014**
Inspector's Name:	**Donna Rogan**
Inspection ID:	**IN017175**

The Regulation And Quality Improvement Authority
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1.0 General Information

Name of Establishment:	Bannview House Care Home
Address:	23 Bannview Road Banbridge BT32 3RL
Telephone Number:	02840660110
Email Address:	johnrafferty@priorygroup.com
Registered Organisation/ Registered Provider:	Priory (Warrenpoint) Ltd Mr Adrian Pancock
Registered Manager:	Mr John Rafferty
Person in Charge of the Home at the Time of Inspection:	Mr John Rafferty
Categories of Care:	15 NH-I, 41 NH-DE 2 NH-PH 22 RC-I
Number of Registered Places:	80
Number of Patients Accommodated on Day of Inspection:	80
Scale of Charges (per week):	NH - £567 + Top Up RC - £450 + Top Up
Date and Type of Previous Inspection:	9 and 21 May and 27 and 30 September 2013 secondary unannounced
Date and Time of Inspection:	20 November 2014 11.00 – 17.45
Name of Inspector:	Donna Rogan

2.0 Introduction

The Regulation and Quality Improvement Authority (RQIA) is empowered under The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003 to inspect nursing homes. A minimum of two inspections per year are required.

This is a report of an inspection to assess the quality of services being provided. The report details the extent to which the standards measured during inspection are being met.

3.0 Purpose of the Inspection

The purpose of this inspection was to consider whether the service provided to patients was in accordance with their assessed needs and preferences and was in compliance with legislative requirements, minimum standards and other good practice indicators. This was achieved through a process of analysis and evaluation of available evidence.

The Regulation and Quality Improvement Authority aims to use inspection to support providers in improving the quality of services, rather than only seeking compliance with regulations and standards. For this reason, annual inspection involves in-depth examination of a limited number of aspects of service provision, rather than a less detailed inspection of all aspects of the service.

The aims of the inspection were to examine the policies, practices and monitoring arrangements for the provision of nursing homes, and to determine the Provider's compliance with the following:

- The HPSS (Quality, Improvement and Regulation) (Northern Ireland) Order 2003.
- The Nursing Homes Regulations (Northern Ireland) 2005.
- The Residential Homes Regulations (Northern Ireland) 2005.
- The Department of Health, Social Services and Public Safety's (DHSSPS) Nursing Homes Minimum Standards (2008).
- Other published standards which guide best practice may also be referenced during the Inspection process.

4.0 Methods/Process

Specific methods/processes used in this inspection include the following: amend as relevant

- Discussion with the Registered Nurse Manager.
- Discussion with Operations Director.
- Discussion with staff.
- Discussion with patients individually and to others in groups.
- Consultation with relatives.
- Review of a sample of policies and procedures.
- Review of a sample of staff training records.
- Review of a sample of staff duty rotas.
- Review of a sample of care plans.
- Review of the complaints, accidents and incidents records.
- Observation during a tour of the premises.
- Evaluation and feedback.

5.0 Consultation Process

During the course of the inspection, the inspector spoke with:

Patients/Residents	**30**
Staff	**12**
Relatives	**4**
Visiting Professionals	**0**

6.0 Inspection Focus

The inspection sought to establish the level of compliance being achieved with respect to the following DHSSPS Nursing Homes Minimum Standard and to assess progress with the issues raised during and since the previous inspection:

Standard 19 - Continence Management

Patients receive individual continence management and support.

The inspector has rated the home's Compliance Level against each criterion and also against each standard.

The table below sets out the definitions that RQIA has used to categorise the service's performance:

Guidance - Compliance Statements		
Compliance Statement	**Definition**	**Resulting Action in Inspection Report**
0 - Not applicable		A reason must be clearly stated in the assessment contained within the inspection report
1 - Unlikely to become compliant		A reason must be clearly stated in the assessment contained within the inspection report
2 - Not compliant	Compliance could not be demonstrated by the date of the inspection.	In most situations this will result in a requirement or recommendation being made within the inspection report
3 - Moving towards compliance	Compliance could not be demonstrated by the date of the inspection. However, the service could demonstrate a convincing plan for full compliance by the end of the Inspection year.	In most situations this will result in a requirement or recommendation being made within the inspection report
4 - Substantially compliant	Arrangements for compliance were demonstrated during the inspection. However, appropriate systems for regular monitoring, review and revision are not yet in place.	In most situations this will result in a recommendation, or in some circumstances a requirement, being made within the inspection report
5 - Compliant	Arrangements for compliance were demonstrated during the inspection. There are appropriate systems in place for regular monitoring, review and any necessary revisions to be undertaken.	In most situations this will result in an area of good practice being identified and comment being made within the inspection report.

7.0 Profile of Service

Bannview House Care Home is a purpose built nursing home. The home is situated in a quiet rural area in close proximity to Banbridge town. The local community, shopping areas, and community services are located nearby.

The home offers bright and spacious accommodation for a maximum of eighty patients provided on two floors.

All bedrooms are single rooms with en-suite shower facilities and are of varying sizes. Each bedroom is appropriately furnished.

There are assisted bathrooms and shower facilities available in both floors of the home ensuring that bathing facilities are available to meet all patients' needs. A range of toilets are also located throughout both floors of the home.

Three lounges of various sizes are available on each floor, and designated lounges have a feature fireplace. A range of seating including recliner chairs is also available.

Each floor has a large and a smaller dining room available for patient use. To encourage socialization between patients round tables have been provided. It was encouraging that eighteen sets of coloured crockery have been provided to assist patients with dementia. Facilities for making a cup of tea or a snack were also available.

The main kitchen is located on the ground floor adjacent to the large dining room.

A treatment room is also located on the ground floor and each floor has two clinical rooms available.

A suitably equipped laundry is also available.

A passenger lift ensures that facilities on the first floor are accessible to all patients and visitors.

An enclosed garden which can be accessed by patients is provided. The home also has its own mini bus transport.

The registration certificate was observed on display. The home is registered to provide care under the following categories of care:

Nursing Care

NH - I	Old age not falling into any other category
NH - PH	Physical disability other than sensory impairment
NH - DE	Dementia

Residential Care

RC-I	Old age not falling into any other category

8.0 Executive Summary

The unannounced/announced inspection of Bannview Care Home was undertaken by Donna Rogan, inspector on 20 November 2014 between 11.00 and 17.45. The inspection was facilitated by Mr John Rafferty, registered manager. Mr Gavin O'Hare Connolly, operations director was conducting a Regulation 29 visit at the time of the inspection. Both were available for verbal feedback at the conclusion of the inspection.

The focus of this inspection was Standard 19: Continence Management and to assess progress with the issues raised during and since the previous inspection.

During the course of the inspection, the inspector met with patients and staff and relatives. The inspector observed care practices, examined a selection of records, and carried out a general inspection of the nursing home environment as part of the inspection process.

Prior to the inspection, the registered persons completed a self-assessment using the criteria outlined in the standards inspected. This self-assessment was received by RQIA on 17 April 2013. The inspector reviewed the responses provided, however, due to a change in inspection focus has been unable to validate all of the statements provided. The comments provided by the registered persons in the self-assessment were not altered in any way by RQIA. See appendix one.

As a result of the previous inspection, fourteen requirements and one recommendation was made. They were reviewed during this inspection. The inspector evidenced that twelve of the requirements and the one recommendation were fully complied with. One requirement was substantially compliant and one requirement was not compliant. Details of the actions taken regarding the previous requirements and recommendation can be viewed in the section immediately following this summary.

Conclusion

The inspector can confirm that at the time of this inspection the delivery of care to patients was evidenced to be of a good standard. There were processes in place to ensure the management of continence care. There were no requirements or recommendations made in regard to this theme.

In addition to the theme inspected the inspectors also reviewed the following;

- Care practices.
- Patients' views.
- Staff comments.
- Relatives views.
- Environment.
- Meals and mealtimes.
- Care records.
- Management and control of infection.

Requirements are made in relation to care practices, the environment, meals and mealtimes, care records and the management and control of infection. A total of, seven requirements are made following this inspection. These requirements are detailed throughout the report and in the quality improvement plan (QIP).

The inspector would like to thank the patients, the registered manager, the operations director, relatives and staff for their assistance and co-operation throughout the inspection process.

9.0 Follow-Up on Previous Issues

No.	Regulation Ref.	Requirements	Action Taken - As Confirmed During This Inspection	Inspector's Validation of Compliance
1	29 (4)	Ensure Regulation 29 reports evidence that previous action plans have been reviewed to ensure any deficits identified have been addressed in a timely manner. The report should detail the appropriate follow up action to be taken, and any progress made to ensure they are addressed.	A review of the Regulation 29 reports evidenced that the action plans were followed up, and the action taken was recorded. A requirement is made that the reports should be anonymised to maintain the confidentially of staff and patients/residents.	Substantially compliant
2	14 (4)	All staff employed in the home should be aware of the local arrangements in place regarding safeguarding vulnerable adults. This should be included as part of the formal induction process and records should be maintained in the home at all times to evidence they have been properly inducted.	All staff spoken with were aware of the local arrangements regarding safeguarding vulnerable adults. A review of the induction programme evidenced that safeguarding vulnerable adults. Induction records were maintained in the home. Following discussion with staff it was evident that inductions were completed at the commencement of employment, training was embedded into practice.	Compliant

		Inductions should not be completed retrospectively. Staff should be able to demonstrate their knowledge when required. Training provided should evidence that the information has been embedded into practice.		
3	20 (1) (c) Schedule 4 (21)	Ensure records pertaining to training are accessible at all times for inspection.	Training records were available for inspection.	Compliant
4	14 (5) and (6)	Ensure any forms of restraint are managed in accordance with best practice and any actions arising following a risk assessment are followed in practice. The management of the identified patient's care should be reviewed to ensure it reflects the outcome of the risk assessment and the plan of care in keeping with best practice.	A review of the care records evidenced that restraint is being managed in keeping with best practice. The identified patients care plan was reviewed and updated to reflect the outcome of the risk assessment and plan of care.	Compliant

5	14 (4)	All staff employed in the home should have sufficient language skills in order to effectively communicate the correct arrangements in the event of a fire or witnessing abuse. All staff should have sufficient language skills to effectively communicate with patients who are living in the home.	All staff spoken with had sufficient language skill and were able to effectively communicate the correct arrangements to take in the event of a fire and what action to take if they witnessed abuse. All staff spoken with were able to communicate with the patients who are living in the home.	Compliant
6	15 and 16	Ensure the deficits raised in patient A, B and Cs' care records are addressed in keeping with best practice. All three care records should be reviewed and updated.	All three care records were updated following the inspection.	Complaint
7	12 (1) (b)	Ensure the overall management of wound care is reviewed to ensure all staff are adhering to best practice. A wound care audit should be conducted and monitored to ensure best practice is implemented.	A review of care records evidenced that wound care is reviewed to ensure staff are adhering best practice. The registered manager confirmed that he conducts a regular wound care audit.	Compliant

		Records should be maintained. A wound care link nurse should be identified in the home and up to date training should be provided to guide staff to best practice. All staff delivering wound care should have up to date training regarding the management of wound care.	Records of the audits are retained. A wound care link nurse has been nominated in the home and provides staff with up to date guidance. Training records confirmed that staff have completed training in the management of wound care and pressure ulcer management.	
8	12 (1)	Ensure that at all times appropriate and timely referrals are made to the relevant health care professionals.	The care records evidenced that referrals to health care professionals are made in an appropriate and timely way.	Compliant
9	20 (1) (a)	Ensure competency and capability assessments are completed following training to validate registered nurses knowledge of wound assessment, management and treatment, including wound care products and dressings.	The registered manager conducts competency and capability assessments in order to validate registered nurses knowledge of the management and treatment of wounds including wound care products and dressings. Registered nurses also confirmed that competency and capability assessments are also completed for the administration of medicines.	Compliant

		All staff administering medicines should also have a competency and capability assessment in place.		
10	32 (h)	Ensure that notice is provided in writing of any changes or alterations, extensions or changes in categories of care are proposed to the RQIA prior to the changes being made.	The treatment room on the ground floor has been changed into an activity storage room. There has been no minor variation application made to RQIA. It is required that before any alterations are made regarding the changes of usage of a rooms that an application is forwarded for approval to RQIA prior to the changes being made. This requirement is stated for a second time.	Not compliant
11	21 Schedule 2	Ensure all the appropriate documentation as listed in Regulation 21 Schedule 2 is provided to the registered manager prior to staff commencing employment in the home.	The registered manager and administrator confirmed that all the required documentation is maintained in accordance with Regulation 21 Schedule 2 prior to staff commencing employment.	Compliant
12	21 Schedule 2 (5)	Ensure sufficient evidence is in place to ensure where applicable that staff are registered with an appropriate professional regulatory body. The employer's confirmation	There was evidence maintained in the home that staff were registered with the appropriate professional bodies. An employer's confirmation check is maintained in the home.	Compliant

		check should be conducted to confirm registration with the NMC.		
13	27 (4) (e)	Ensure that all persons working at the nursing home receives suitable training of the local arrangements in the event of the fire alarm sounding or detecting a fire.	A review of the training records evidenced that all persons working at the nursing home have received training in the local arrangements in the event of the fire alarm sounding.	Compliant
14	27 (4) (f)	Ensure fire drill records contain sufficient information to ascertain if fire drills are effective and to ascertain if all staff acted appropriately. Relevant information pertaining to the drill should be in place this should include which zone the alarm was sounded, staff reaction, if it was unannounced, the issues arising and any learning for the team. Provide to the RQIA the written fire management plan to advise staff of the	Fire drills contain sufficient information regarding the effectiveness of staff actions when the fire alarm sounds. Relevant information is retained in the fire drill record. The inspector can confirm that the written fire management plan was received by RQIA.	Complaint

		action to be taken in the event of a fire.		

No.	Minimum Standard Ref.	Recommendations	Action Taken - As Confirmed During This Inspection	Inspector's Validation of Compliance
1	29 (5)	Ensure information is placed on the patient/relatives' notice board informing patients and their representatives that copies of the Regulation 29 unannounced visit reports were available on request.	There is a notice displayed on the patient/relatives' notice board informing them of the availability of the Regulation 29 reports.	Compliant

9.0 Follow up on any issues/concerns raised with RQIA since the previous inspection such as complaints or safeguarding investigations.

It is not in the remit of RQIA to investigate complaints made by or on the behalf of individuals, as this is the responsibility of the providers and commissioners of care. However, if RQIA is notified of a breach of regulations or associated standards, it will review the matter and take whatever appropriate action is required; this may include an inspection of the home.

Since the previous care inspection RQIA have received a notification of a safeguarding allegation. RQIA are satisfied that the allegation is being investigated and the correct action has been taken by the home in accordance with departmental guidelines. The outcome of the investigation should be shared with RQIA upon conclusion alongside the action taken (if any) by management in the home.

10.0 Inspection Findings

Standard 19 - Continence Management Patients receive individual continence management and support	
Criterion Assessed: 19.1 Where patients require continence management and support, bladder and bowel continence assessments are carried out. Care plans are developed and agreed with patients and representatives, and, where relevant, the continence professional. The care plans meet the individual's assessed needs and comfort.	**Compliance Level**
Inspection Findings:	
Review of four patients' care records evidenced that bladder and bowel continence assessments were undertaken for patients. The outcome of these assessments, including the type of continence products to be used, was incorporated into the patients' care plans on continence care. There was evidence in the patients care records that bladder and bowel assessments and continence care plans were reviewed and updated on a monthly basis or more often as deemed appropriate. The promotion of continence, skin care, fluid requirements and patients' dignity were addressed in the care plans inspected. Urinalysis was undertaken and patients were referred to their GPs as appropriate. Review of the patient's care records and discussion with patients evidenced that either they or their representatives had been involved in discussions regarding the agreeing and planning of nursing interventions. The care plans reviewed addressed the patients' assessed needs in regard to continence management. Discussion with staff and observation during the inspection evidenced that there were adequate stocks of continence products available in the nursing home.	Compliant

Standard 19 - Continence Management Patients receive individual continence management and support	
Criterion Assessed: 19.2 There are up-to-date guidelines on promotion of bladder and bowel continence, and management of bladder and bowel incontinence. These guidelines also cover the use of urinary catheters and stoma drainage pouches, are readily available to staff and are used on a daily basis.	**Compliance Level**
Inspection Findings:	
The inspector can confirm that the following policies and procedures were in place; • Continence management/incontinence management. • Stoma care. • Catheter care. The inspector can also confirm that the following guideline documents were in place: • RCN continence care guidelines. • NICE guidelines on the management of urinary incontinence. • NICE guidelines on the management of faecal incontinence. Discussion with staff revealed that they had an awareness of these policies, procedures and guidelines.	Compliant

Standard 19 - Continence Management Patients receive individual continence management and support	
Criterion Assessed: 19.3 There is information on promotion of continence available in an accessible format for patients and their representatives.	**Compliance Level**
Inspection Findings:	
Not inspected	Not applicable
Criterion Assessed: 19.4 Nurses have up-to-date knowledge and expertise in urinary catheterisation and the management of stoma appliances.	**Compliance Level**
Inspection Findings:	
Discussion with the registered manager and review of training records confirmed that staff were trained and assessed as competent in continence care. Discussion with the registered manager revealed that a number of registered nurses in the home were deemed competent in female catheterisation and the management of stoma appliances.	Compliant

Inspector's overall assessment of the nursing home's compliance level against the standard assessed	**Compliant**

11.0 Additional Areas Examined

11.1 Care Practices

During the inspection staff were noted to treat the patients with dignity and respect. Good relationships were evident between patients and staff.

Patients were well presented with their clothing suitable for the season. Staff were observed to respond to patients' requests promptly. The demeanour of patients indicated that they were relaxed in their surroundings.

The afternoon routine was observed to be well organised. Patients spoken with stated that they could choose where to have their lunch. Patients also informed the inspector that their continence needs were tended to in a timely way, they stated that when they sounded the nurse call system that their request was usually answered promptly.

There was a good atmosphere in the home. There is a well organised activity programme ongoing on a Wednesday, Thursday and Friday. Patients spoken with stated they enjoyed the activities organised and were looking forward to the social activities organised for Christmas. It is required that organised activities are also arranged on a Monday and Tuesday. A requirement is made in this regard.

11.2 Complaints

A complaints questionnaire was forwarded by the Regulation and Quality Improvement Authority (RQIA) to the home for completion. The evidence provided in the returned questionnaire indicated that complaints were being pro-actively managed.

The inspector discussed the management of complaints with the registered manager and reviewed the complaint record. This evidenced that complaints were managed in a timely manner and in accordance with legislative requirements.

11.3 Patient Finance Questionnaire

Prior to the inspection a patient financial questionnaire was forwarded by RQIA to the home for completion. The evidence provided in the returned questionnaire indicated that patients' monies were being managed in accordance with legislation and best practice guidance.

11.4 NMC Declaration

Prior to the inspection the registered manager was asked to complete a proforma to confirm that all nurses employed were registered with the Nursing and Midwifery Council of the United Kingdom (NMC).

The evidence provided in the returned proforma indicated that all nurses, including the registered manager, were appropriately registered with the NMC.

11.5 Patients/Residents and Relatives Comments

During the inspection the inspector spoke with approximately 30 patients individually and to others in groups. These patients expressed high levels of satisfaction with the standard of care,

facilities and services provided in the home. A number of patients were unable to express their views verbally. These patients indicated by positive gestures that they were happy living in the home. Examples of patients' comments were as follows:

"Staff are attentive and kind"
"We are well looked after"
"I've everything I need, I'm content"
"It's a lovely home, great staff and I have a lovely room"
"I have no complaints"

The inspector also spoke with four relatives visiting at the time of the inspection. All were very positive regarding the care their relatives were receiving in the home. They were confident that they could approach management if they had any issues in the home. All stated that they felt they were kept well informed of changes in their relatives needs and felt they were involved in their care. There were no issues raised by patients/residents or relatives to the inspector during the inspection.

11.6 Staff Comments

During the inspection the inspector spoke with 12 staff. The inspector was able to speak to a number of these staff individually and in private. Staff responses during discussion indicated that staff received an induction, completed mandatory training, completed additional training in relation to continence care and were very satisfied or satisfied that patients were afforded privacy, treated with dignity and respect and were provided with care based on need and wishes.

Examples of staff comments were as follows;

"Patients and residents are all well cared for"
"I am happy working here"
"The manager is approachable if I have any issues I wouldn't be afraid to raise them"
"Staffing levels have improved, we don't use agency at all now"

11.7 Environment

The inspector undertook an inspection of the premises and viewed the majority of the patients' bedrooms, bathroom, shower and toilet facilities and communal areas. The home was comfortable and all areas were maintained to a high standard of hygiene. The following issues are required to be addressed;

- Ensure an application regarding the change of use of the treatment room on the ground floor is forwarded to RQIA without delay.
- Ensure the foul odour is eradicated in the identified bathroom.
- Ensure the temperature in the residential unit dining room is maintained comfortable and warm.
- Ensure the items stored in the staff shower room is removed, this shower room is required to be thoroughly cleaned. The registered manager informed the inspector that this room is not used. It is required that the toilet is regularly flushed and the water in the sink is run regularly in the interests of legionella management. Records should be maintained.
- The use of signage and use of memory boxes should be reviewed in the dementia units.

11.8 Meals and mealtimes

The inspector observed the serving of the serving of the lunchtime meal. The meal served was observed to be very appetising. All patients/residents spoken with expressed complete satisfaction with the food in the home. The lunchtime meal is the main meal of the day and it consisted of a choice of meatballs or turkey served with mashed or boiled potato, cauliflower cheese, green beans and gravy. The desert was ice cream and fruit or jelly. The microwaves in the patient/residents serveries should be thoroughly cleaned. The menus should be prominently displayed in the dining rooms in a suitable format to meet the needs of patients/residents.

11.9 Care records

The inspector reviewed four patient/residents care records and a number of repositioning charts, fluid balance charts and nutritional intake charts. In general records are being well maintained in accordance with best practice. However the following issues should be addressed;

- Ensure fluid balance charts are competed in sufficient detail. This should include the intake and output amount.
- Ensure that the consistency of fluids to be given is included on the fluid balance charts.
- Ensure details of mouth care delivered are sufficiently recorded.
- Ensure the exact time that fluids are given/offered is recorded.
- Ensure patients' weights are appropriately carried out in keeping with their needs and records are maintained.
- Ensure that when patients/residents needs change that the care plan is updated in a clear and concise manner.

11.10 Management and control of infection

There have been a number of infection control audits carried out and they are usually completed monthly. However on the day of inspection a number of infection control issues were identified. The registered manager agreed to address the following issues;

- Ensure all creams and lotions are appropriately labelled.
- Ensure toiletries are individualised and only used by the person who own them.
- Ensure the management of patients oral hygiene is reviewed and that toothbrushes and tooth mugs are appropriately cleaned and stored after use.

12.0 Quality Improvement Plan

The details of the Quality Improvement Plan appended to this report were discussed with John Rafferty, registered manager as part of the inspection process.

The timescales for completion commence from the date of inspection.

The registered provider/manager is required to record comments on the Quality Improvement Plan.

Matters to be addressed as a result of this inspection are set in the context of the current registration of your premises. The registration is not transferable so that in the event of any future application to alter, extend or to sell the premises the RQIA would apply standards current at the time of that application.

Enquiries relating to this report should be addressed to:

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BT1 3BT

Appendix 1

Section A	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 5.1 • **At the time of each patient's admission to the home, a nurse carries out and records an initial assessment, using a validated assessment tool, and draws up an agreed plan of care to meet the patient's immediate care needs. Information received from the care management team informs this assessment.** **Criterion 5.2** • **A comprehensive, holistic assessment of the patient's care needs using validated assessment tools is completed within 11 days of admission.** **Criterion 8.1** • **Nutritional screening is carried out with patients on admission, using a validated tool such as the 'Malnutrition Universal Screening Tool (MUST)' or equivalent.** **Criterion 11.1** • **A pressure ulcer risk assessment that includes nutritional, pain and continence assessments combined with clinical judgement is carried out on all patients prior to admission to the home where possible and on admission to the home.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulations12(1)and (4);13(1); 15(1) and 19 (1) (a) schedule 3**	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
At the time of each patient's admission to the home, a delegated nurse carries out and records an initial risk assessment, using a validated assessment tool, and draws up an agreed plan of care to meet the patient's immediate care needs. Information received from the care management team and key stakeholders where relevant informs this assessment. A comprehensive, holistic assessment of the patient's care needs using validated assessment tools is completed within 11 days of admission. Nutritional screening is carried out with patients on admission, using a validated tool such as the 'Malnutrition Universal	Compliant

Screening Tool (MUST)' or equivalent. Staff has been trained in implementing the assessment. A pressure ulcer risk assessment that includes nutritional, pain and continence assessments combined with clinical judgement is carried out on all patients prior to admission to the home where possible, and on admission to the home.	

Section B	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 5.3 • **A named nurse has responsibility for discussing, planning and agreeing nursing interventions to meet identified assessed needs with individual patients' and their representatives. The nursing care plan clearly demonstrates the promotion of maximum independence and rehabilitation and, where appropriate, takes into account advice and recommendations from relevant health professional.** **Criterion 11.2** • **There are referral arrangements to obtain advice and support from relevant health professionals who have the required expertise in tissue viability.** **Criterion 11.3** • **Where a patient is assessed as 'at risk' of developing pressure ulcers, a documented pressure ulcer prevention and treatment programme that meets the individual's needs and comfort is drawn up and agreed with relevant healthcare professionals.** **Criterion 11.8** • **There are referral arrangements to relevant health professionals who have the required knowledge and expertise to diagnose, treat and care for patients who have lower limb or foot ulceration.** **Criterion 8.3** • **There are referral arrangements for the dietician to assess individual patient's nutritional requirements and draw up a nutritional treatment plan. The nutritional treatment plan is developed taking account of recommendations from relevant health professionals, and these plans are adhered to.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulations13 (1);14(1); 15 and 16**	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
A named nurse has responsibility for discussing, planning and agreeing nursing interventions to meet identified assessed needs with individual patients and their representatives. The nursing care plan clearly demonstrates the promotion of maximum independence and rehabilitation and, where appropriate, takes into account advice and	Compliant

recommendations from relevant health professionals. There are referral arrangements to obtain advice and support from relevant health professionals who have the required expertise in tissue viability. Where a patient is assessed as 'at risk' of developing pressure ulcers, a documented pressure ulcer prevention and treatment programme that meets the individual's needs and comfort is drawn up and agreed with relevant professionals. There are referral arrangements to relevant health professionals who have the required knowledge and expertise to diagnose, treat and care for patients who have lower limb or foot ulceration. There are referral arrangements for the dietician to assess individual patient's nutritional requirements and draw up a nutritional treatment plan. The nutritional treatment plan is developed taking account of recommendations from relevant health professionals, and these plans are adhered to. The March 2014 PHA Nutritional Guidelines and Menu Checklist for residential and nursing homes has also been implemented into operational practices	

Section C	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 5.4 • **Re-assessment is an on-going process that is carried out daily and at identified, agreed time intervals as recorded in nursing care plans.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulations 13 (1) and 16**	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
Ongoing assessments and re-assessment is a requirement that is carried out daily and at identified, agreed time intervals as recorded in nursing care plans.	Compliant

Section D	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 5.5 • **All nursing interventions, activities and procedures are supported by research evidence and guidelines as defined by professional bodies and national standard setting organisations.** **Criterion 11.4** • **A validated pressure ulcer grading tool is used to screen patients who have skin damage and an appropriate treatment plan implemented.** **Criterion 8.4** • **There are up to date nutritional guidelines that are in use by staff on a daily basis.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulation 12 (1) and 13(1)**	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
All nursing interventions, activities and procedures are supported by research evidence and guidelines as defined by professional bodies and national standard setting organisations. Best practice is promoted at all times. The Care Home is striving to achieve excellence. A validated pressure ulcer grading tool is used to screen patients who have skin damage and an appropriate treatment plan implemented. There are up to date nutritional guidelines that are used by staff on a daily basis. The latest March 2014 PHA Nutritional guidelines is being introduced into practice.	Compliant

Section E	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 5.6 • **Contemporaneous nursing records, in accordance with NMC guidelines, are kept of all nursing interventions, activities and procedures that are carried out in relation to each patient. These records include outcomes for patients.** **Criterion 12.11** • **A record is kept of the meals provided in sufficient detail to enable any person inspecting it to judge whether the diet for each patient is satisfactory.** **Criterion 12.12** • **Where a patient's care plan requires, or when a patient is unable, or chooses not to eat a meal, a record is kept of all food and drinks consumed.** **Where a patient is eating excessively, a similar record is kept.** **All such occurrences are discussed with the patient are reported to the nurse in charge. Where necessary, a referral is made to the relevant professionals and a record kept of the action taken.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulation/s 12 (1) & (4), 19(1) (a) schedule 3 (3) (k) and 25**	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
Contemporaneous nursing records, in accordance with NMC guidelines, are kept of all nursing interventions, activities and procedures that are carried out in relation to each patient. These records include outcomes for patients. A record is kept of the meals provided in sufficient detail to enable any person inspecting it to judge whether the diet for each patient is satisfactory. Where a patient's care -plan requires, or when a patient is unable, or chooses not, to eat a meal, a record is kept of all food and drinks consumed. Where a patient is eating excessively, a similar record is kept. All such occurrences are discussed with the patient and reported to the nurse in charge and the Chef. Where necessary, a referral is made to the relevant professionals and a record kept of the action taken.	Compliant

Section F	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 5.7 • **The outcome of care delivered is monitored and recorded on a day-to-day basis and, in addition, is subject to documented review at agreed time intervals and evaluation, using benchmarks where appropriate, with the involvement of patients and their representatives.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulation 13 (1) and 16**	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
The outcome of care delivered is monitored and recorded on a day-to-day basis and, in addition, is subject to documented review at agreed time intervals and evaluation, using benchmarks where appropriate, with the involvement of patients and their representatives.	Compliant

Section G	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 5.8 • **Patients are encouraged and facilitated to participate in all aspects of reviewing outcomes of care and to attend, or contribute to, formal multidisciplinary review meetings arranged by local HSC Trusts as appropriate.** **Criterion 5.9** • **The results of all reviews and the minutes of review meetings are recorded and, where required, changes are made to the nursing care plan with the agreement of patients and representatives. Patients, and their representatives, are kept informed of progress toward agreed goals.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulation/s 13 (1) and 17 (1)**	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
Patients are invited, encouraged and facilitated to participate in all aspects of reviewing outcomes of care and to attend, or contribute to, formal multi-disciplinary review meetings arranged by local HSC Trusts as appropriate. The results of all reviews and the minutes of review meetings are recorded and, where required, changes are made to the nursing care plan with the agreement of patients and representatives. Patients, and their representatives, are kept informed of progress toward agreed goals. Patient involvement and collaboration is present in all aspects of the Care Home.	Compliant

Section H	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 12.1 • **Patients are provided with a nutritious and varied diet, which meets their individual and recorded dietary needs and preferences.** **Full account is taken of relevant guidance documents, or guidance provided by dieticians and other professionals and disciplines.** **Criterion 12.3** • **The menu either offers patients a choice of meal at each mealtime or, when the menu offers only one option and the patient does not want this, an alternative meal is provided.** **A choice is also offered to those on therapeutic or specific diets.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulation/s 12 (1) & (4), 13 (1) and 14(1)**	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
Patients are provided with a nutritious and varied diet, which meets their individual and recorded dietary needs and preferences. Full account is taken of relevant guidance documents, or guidance provided by dieticians and other professionals and disciplines. Patients are involved in planning the menus. The menu always offers patients a choice of meal at each mealtime or, when the menu offers only one option and the patient does not want this, an alternative meal is provided. A choice is also offered to those on therapeutic or specific diets. Patient satisfaction surveys are completed anonymously to evaluate the standard of food and the dining experience offering respondents the opportunity to forward suggestions on how to improve the service. Resident and relatives meetings are held faciliting evaluation and feedback on the standard of service provided.	Compliant

Section I	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 8.6 • **Nurses have up to date knowledge and skills in managing feeding techniques for patients who have swallowing difficulties, and in ensuring that instructions drawn up by the speech and language therapist are adhered to.** **Criterion 12.5** • **Meals are provided at conventional times, hot and cold drinks and snacks are available at customary intervals and fresh drinking water is available at all times.** **Criterion 12.10** • **Staff are aware of any matters concerning patients' eating and drinking as detailed in each individual care plan, and there are adequate numbers of staff present when meals are served to ensure:** o **risks when patients are eating and drinking are managed** o **required assistance is provided** o **necessary aids and equipment are available for use.** **Criterion 11.7** • **Where a patient requires wound care, nurses have expertise and skills in wound management that includes the ability to carry out a wound assessment and apply wound care products and dressings.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulation/s 13(1) and 20**	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
Nurses have up-to-date knowledge and skills in managing feeding techniques for patients who have swallowing difficulties, and in ensuring that instructions drawn up by the speech and language therapist are adhered to. Meals are provided at conventional times, hot and cold drinks and snacks are available at customary intervals and fresh drinking water is available at all times. Staff are aware of any matters concerning patients' eating and drinking as detailed in each patient's individual care plan, and there are adequate numbers of staff present when meals are served to ensure: • Risks when patients are eating and drinking are managed • Required assistance is provided	Compliant

• Necessary aids and equipment are available for use. Where a patient requires wound care, nurses have expertise and skills in wound management that includes the ability to carry out a wound assessment and apply wound care products and dressings.	

Provider's Overall Assessment of the Nursing Home's Compliance Level Against Standard 5	Compliance Level
	Compliant

Appendix 2

Explanation of coding categories as referenced in the Quality of Interaction Schedule (QUIS)

Positive social (PS) – care over and beyond the basic physical care task demonstrating patient centred empathy, support, explanation, socialisation etc.	**Basic care: (BC) – basic physical care e.g. bathing or use if toilet etc. with task carried out adequately but without the elements of social psychological support as above. It is the conversation necessary to get the task done.**
• Staff actively engage with people e.g. what sort of night did you have, how do you feel this morning etc. (even if the person is unable to respond verbally). • Checking with people to see how they are and if they need anything. • Encouragement and comfort during care tasks (moving and handling, walking, bathing etc.) that is more than necessary to carry out a task. • Offering choice and actively seeking engagement and participation with patients. • Explanations and offering information are tailored to the individual, the language used easy to understand, and non-verbal used were appropriate. • Smiling, laughing together, personal touch and empathy. • Offering more food/ asking if finished, going the extra mile. • Taking an interest in the older patient as a person, rather than just another admission. • Staff treat people with respect addressing older patients and visitors respectfully, providing timely assistance and giving an explanation if unable to do something right away. • Staff respect older people's privacy and dignity by speaking quietly with older people about private matters and by not talking about an individual's care in front of others.	Examples include: Brief verbal explanations and encouragement, but only that the necessary to carry out the task. No general conversation.

Neutral (N) – brief indifferent interactions not meeting the definitions of other categories.	**Negative (NS) – communication which is disregarding of the residents' dignity and respect.**
Examples include: • Putting plate down without verbal or non-verbal contact. • Undirected greeting or comments to the room in general. • Makes someone feel ill at ease and uncomfortable. • Lacks caring or empathy but not necessarily overtly rude. • Completion of care tasks such as checking readings, filling in charts without any verbal or non-verbal contact. • Telling someone what is going to happen without offering choice or the opportunity to ask questions. • Not showing interest in what the patient or visitor is saying.	**Examples include:** • Ignoring, undermining, use of childlike language, talking over an older person during conversations. • Being told to wait for attention without explanation or comfort. • Told to do something without discussion, explanation or help offered • Being told can't have something without good reason/ explanation. • Treating an older person in a childlike or disapproving way. • Not allowing an older person to use their abilities or make choices (even if said with 'kindness'). • Seeking choice but then ignoring or over ruling it. • Being angry with or scolding older patients. • Being rude and unfriendly. • Bedside hand over not including the patient.

References

QUIS originally developed by Dean, Proudfoot and Lindesay (1993). The quality of interactions schedule (QUIS): development, reliability and use in the evaluation of two domus units. *International Journal of Geriatric Psychiatry* Vol *pp 819-826.

QUIS tool guidance adapted from Everybody Matters: Sustaining Dignity in Care. London City University.

Quality Improvement Plan

Secondary Unannounced Care Inspection

Bannview Private Nursing Home

20 November 2014

The areas where the service needs to improve, as identified during this inspection visit, are detailed in the inspection report and Quality Improvement Plan.

The specific actions set out in the Quality Improvement Plan were discussed with Mr John Rafferty, registered manager during the inspection visit.

Any matters that require completion within 28 days of the inspection visit have also been set out in separate correspondence to the registered persons.

Registered providers / managers should note that failure to comply with regulations may lead to further enforcement and/ or prosecution action as set out in The HPSS (Quality, Improvement and Regulation) (Northern Ireland) Order 2003.

It is the responsibility of the registered provider / manager to ensure that all requirements and recommendations contained within the Quality Improvement Plan are addressed within the specified timescales.

Matters to be addressed as a result of this inspection are set in the context of the current registration of your premises. The registration is not transferable so that in the event of any future application to alter, extend or to sell the premises the RQIA would apply standards current at the time of that application.

Statutory Requirements

This section outlines the actions which must be taken so that the Registered Person/s meets legislative requirements based on The HPSS (Quality, Improvement and Regulation) (Northern Ireland) Order 2003, and The Nursing Homes Regulations (NI) 2005

No.	Regulation Reference	Requirements	Number Of Times Stated	Details Of Action Taken By Registered Person(S)	Timescale
1	29 (4)	Ensure the Regulation 29 reports are anonymised to maintain patients/residents' and staffs' confidentially. **Ref previous requirements**	One	The Operational Director report identified and written by Sheila King has been amended and anonymised. All current reports are adhering to this requirement.	From the date of inspection
2	32 (h)	Ensure that notice is provided in writing of any changes or alterations, extensions or changes in categories of care are proposed to the RQIA prior to the changes being made. **Ref previous requirements**	Two	The room that is being used by the Social and Leisure organiser has been identified as a change of use to Estates Services at RQIA.	From the date of inspection
3	18 (2) (n)	Ensure activities are planned and provided on a Monday and Tuesday in keeping with the needs and choices of patients/residents **Ref 11.1**	One	Activities are available on Monday and Tuesday of each week. Hairdressing is also available on these days and Staff are implementing the Creative Minds Programme on these days as well.	From the date of inspection
4	27	Ensure the following issues are addressed in relation to the environment; Ensure an application regarding the change of use of the treatment room on the ground floor is forwarded to RQIA without delay. Ensure the foul odour is eradicated in the identified bathroom.	One	An application is submitted to RQIA for change of use of the vacant room previously identified as a treatment room on the plans for the Care Home; The odour that had arisen from the waste disposal pipe in the bathroom was resolved and has not returned;	From the date of inspection

		Ensure the temperature in the residential unit dining room is maintained comfortable and warm. Ensure the items stored in the staff shower room is removed, this shower room is required to be thoroughly cleaned. Ensure that the identified toilet is regularly flushed and the water in the identified sink is also run regularly in the interests of legionella management. Records should be maintained. The use of signage and use of memory boxes should be reviewed in the dementia units. **Ref 11.7**		The temperature in the residential unit dining room i corrected and is satisfactory; The items in the staff shower room are removed and the shower room is clean presented to a high standard; The identified toilet has been flushed the identified sink is run daily. A record will be maintained in the Scarva cleaning record file. The signage and the use of Memory Boxes in the dementia units has been reviewed with the Northern Ireland Dementia Coach. where improvements can be made this will be put into practice.A family Focus Group meeting has been advertised and the memory boxes is included in the agenda so that best practice is implemented.	
5	12 (1) (b)	Ensure the microwaves in the serveries are thoroughly cleaned following their use. Menus should be appropriately displayed in a suitable format to meet the needs of patients/residents. **Ref 11.8**	One	A directive has been issued to all staff requiring all microwaves to be cleaned twice daily during the day and during the night. This directive has been implemented in full. The menus are currently being reviewed along with the Dementia Coach for Northern	From the date of inspection

				Ireland. Menus will be displayed on each table daily.	
6	13 (7)	Ensure the following issues are addressed regarding the management and control of infection; Ensure all creams and lotions are appropriately labelled. Ensure toiletries are individualised and only used by the person who own them. Ensure the management of patients' oral hygiene is reviewed and that toothbrushes and tooth mugs are appropriately cleaned and stored after use. **Ref 11.10**	One	All creams and lotions have been checked and where any labels are missing are removed from use; All toiletries are individualised and will only be used by the resident who owns them; The management of residents oral hygiene and a memo has been forwarded to all staff detailing expected best practice. The expected practices are being monitored daily.	From the date of inspection
7	12 (1) (b)	The registered manager shall ensure the following issues are addressed regarding care records as follows; Ensure fluid balance charts are competed in sufficient detail. This should include the intake and output amount. Ensure that the consistency of fluids to be given is included on the fluid balance charts. Ensure details of mouth care delivered are sufficiently recorded. Ensure the exact time that fluids are given/offered is recorded.	One	Fluid balance charts will contain the required detail identified during the inspection; The fluid balance charts will also detail the consistency of fluids provided; Details of mouthcare delivered will be recorded daily; Times/dates of fluids that are given/offered will be recorded daily Residents weights are recorded regularly and records maintained; Care plans are updated as the residents needs change in a	From the date of inspection

		Ensure patients' weights are appropriately carried out in keeping with their needs and records are maintained. Ensure that when patients/residents needs change that the care plan is updated in a clear and concise manner. **Ref 11.9**		clear and concise manner.	

Please complete the following table to demonstrate that this Quality Improvement Plan has been completed by the registered manager and approved by the responsible person/identified responsible person:

NAME OF REGISTERED MANAGER COMPLETING QIP	John Rafferty
NAME OF RESPONSIBLE PERSON / IDENTIFIED RESPONSIBLE PERSON APPROVING QIP	Caroline Denny

QIP Position Based on Comments from Registered Persons	**Yes**	**Inspector**	**Date**
Response assessed by inspector as acceptable	Yes	Donna Rogan	19/01/15
Further information requested from provider			